"INSURING BRIGHT FUTURES: IMPROVING ACCESS TO DENTAL CARE AND PROVIDING A HEALTHY START FOR CHILDREN"

TESTIMONY

OF

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BEFORE THE

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Good morning Chairman Pallone, Representative Deal and members of the Subcommittee. My name is Chris Koyanagi. I am the policy director for the Judge David L. Bazelon Center for Mental Health Law. The Bazelon Center is the leading national nonprofit, legal-advocacy organization representing people with mental disabilities. The Center works to define and uphold the rights of adults and children with mental disabilities who primarily rely on public services to ensure that they have equal access to health and mental health care, education, housing and employment.

Thank you for the opportunity to share our insights regarding mental health care for children in the public and private sector, including barriers to care, the consequences of inadequate access to care, and opportunities for Congress to improve access and provide a healthy start for children with mental health needs. It is our hope that this hearing will result in increased support for specific legislative proposals that will provide appropriate and timely access to mental health services and supports in both the public and private sectors.

During my testimony, I will describe opportunities within the Committee's jurisdiction to address shortcomings in health care coverage for children with mental health needs such as approving the bipartisan Paul Wellstone Mental Health and Addiction Equity Act, enacting the bipartisan Keeping Families Together Act, eliminating the discriminatory limits on mental health care in State Children's Health Insurance Program (SCHIP), and preserving and strengthening the public sector Medicaid program.

OVERVIEW OF CHILDREN'S MENTAL HEALTH

Mental disorders affect about one in five American children and five to nine percent experience serious emotional disturbances that severely impair their functioning. Children from

low-income households are at increased risk of mental health problems and research has indicated that children in Medicaid and SCHIP have a much higher prevalence of mental health problems than other insured children or even uninsured children. Tragically, a large majority of children struggling with these mental disorders (79% by some estimates) do not receive the mental health services they need. Not surprisingly, uninsured children have a higher rate of unmet need than children with public or private insurance.

More than just a problem for the uninsured, children covered by private or public health plans have serious coverage gaps that prevent them from obtaining needed mental health services. For instance, private health plans set arbitrary limits on mental health coverage, such as caps on the number of times a child may be seen by a therapist over the course of a year. Approximately 68% of Americans under the age of 18 are covered by private insurance, while public programs (such as Medicaid and SCHIP) cover about 19 percent.

Within the public sector, discriminatory limits on mental health services in SCHIP that would not be permissible in Medicaid have restricted access to care for children and adolescents. Additionally, current Administrative activities that restrict reimbursement under the Medicaid rehabilitative services option limit access to a range of critical community-based services for children and adults that help them remain in the community—a goal supported by the President's Commission on Mental Health.

Without early and effective identification and intervention, childhood mental disorders can lead to a downward spiral of school failure, poor employment outcomes, and, later poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with

the juvenile justice system, and children with mental disorders are a much higher risk of suicide. According to the Surgeon General, an estimated 90% of children who commit suicide have a mental disorder.

Fortunately, poor outcomes for children with mental health needs can be prevented with access to appropriate services.

INSURANCE REFORM NEEDED TO IMPROVE ACCESS AND AVOID TRAGIC OUTCOMES

Mental health treatment can be very expensive and most families rely upon insurance to help cover the cost of these services. For example, one outpatient therapy session can cost more than $100. Residential treatment facilities, which provide 24 hours of care, seven days a week, can cost $250,000 a year or more. However, employer based coverage often restricts access to mental health services for children and adults by placing limits on mental health coverage that they do not place on medical/surgical care. Limits on mental health coverage includes lower outpatient office visit limits, lower hospital stay limits, higher outpatient office visit co-payments, and higher outpatient office visit co-insurance. Data show that 94% of health maintenance plans and 96% of other plans have these restrictions. Families that face health insurance restrictions or exhaust their health insurance benefits are left without options.

Enacting mental health parity legislation (sponsored by Representatives Patrick Kennedy and Jim Ramstad) would be an essential first step to improving access in the private sector. Comprehensive parity legislation would help by prohibiting private insurers from denying access to needed services because of stigma and discrimination through current limitations and restrictions on mental health care that are not placed on general health care. Additionally, this

federal legislation would extend parity protections to the many self-funded employer-sponsored plans, that are currently exempt from any state mental health parity laws.

Gaps in services and limits in coverage can be disastrous and could lead to custody relinquishment whereby parents of children with mental disorders forgo custody of their children so they can become wards of the state and eligible for medical assistance. It is clear that across the country, children needing intensive mental health treatment are not receiving the care they need early on to prevent a host of adverse outcomes, including custody relinquishment. According to a General Accounting Office (GAO) report of April 2003, at least 12,700 children were placed in child welfare or juvenile justice system in 2001, solely to access state-funded mental health services. But this finding grossly understates the extent of the problem. GAO also found that most states and counties do not track how often custody relinquishment occurs and the 12,700 figure only reflects data from 19 child welfare departments and 30 county-level juvenile justice systems.

Legislation entitled the Keeping Families Together Act (H.R. 687/S. 382) has been introduced to help prevent parents from having to choose between custody and care by funding state-level interagency systems of care to improve mental health sources for children with mental disorders at risk of or already subjected to custody relinquishment. This legislation is sponsored by Representatives Patrick Kennedy, Jim Ramstad, and Pete Stark and Senators Susan Collins and Tom Harkin. It has been referred to the Energy and Commerce Committee and we urge the Committee to approve this crucial piece of legislation as soon as possible.

Many families cite gaps in private insurance coverage as a major factor in their decisions to relinquish custody of their children. Private insurance plans do not cover the full array of intensive, community-based rehabilitative services that children with the most severe mental or emotional disorders need—services that would be covered under Medicaid.

MEDICAID PROVIDES VITAL ACCESS TO MENTAL HEALTH SERVICES

Medicaid is a critical source of support for mental health care, accounting for 20% of all mental health spending. Thanks in large part to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Medicaid covers a comprehensive array of mental health services for children, including intensive services in the community that offer the greatest potential for avoiding costly institutional care. Medicaid is the only source of coverage that finances a full range of the rehabilitative services needed by children with mental disorders.

Last Congress, the bipartisan Family Opportunity Act was enacted as part of the Deficit Reduction Act to give states the option of allowing families with children with disabilities to buy Medicaid coverage for their children. This new law also created a demonstration program to provide home and community- based services to children with serious emotional and behavioral disorders as alternatives to psychiatric residential treatment. Enactment of these important provisions were a significant step in strengthening the Medicaid program by enabling families to meet their children's serious health and mental health needs while still keeping their families intact.

Further steps that must be taken include strengthening the Medicaid EPSDT benefit so that all children served by Medicaid, including those with mental health disorders, receive

comprehensive screening. Non-compliance with EPSDT leads to reduced access to services and puts children in need of treatment at great risk of experiencing a host of other adverse consequences.

Medicaid coverage of community-based services through the rehabilitative services option is also critically important for children with mental health needs, especially children with serious disorders. These intensive rehabilitative community-based services for kids include multisystemic therapy, intensive home-based services for children and adolescents, therapeutic foster care, and behavioral aide services. These services are effective alternatives to institutional care for children and adults with severe mental disorders and are critical to promoting resiliency and recovery from mental illness. Medicaid is generally, the only source of coverage for them, specifically through the rehabilitative services option.

Unfortunately, the Administration has indicated it will narrow coverage under the rehabilitative services option through regulatory changes. During the Deficit Reduction Act deliberations last Congress, Members deliberately rejected the Administration's proposed changes to Medicaid coverage of rehabilitative services. Nonetheless, the Administration is currently going forward with narrowing the scope of the rehabilitation option through the regulatory process as well as changes in coverage policy implemented through audits by the Health and Human Services Office of the Inspector General. The integrity of the Medicaid program and the standards set by Congress regarding the scope of optional service programs must be maintained. The back door approach being used by the Administration, and shunned by Congress in the recent past, would drastically affect specific interventions that enable children

and adults with serious mental disorders to function independently, learn in school, socialize age appropriately and experience symptom reduction.

SCHIP CHANGES REQUIRED TO ELIMINATE DISPARITIES AND IMPROVE ACCESS

SCHIP has generally been very successful in expanding health care coverage to millions of previously uninsured children, and states that simply expanded their Medicaid programs to cover these additional children offer comprehensive mental health services. However, states have the option to establish stand-alone SCHIP plans that are separate from their Medicaid programs and modeled after private insurance benchmark plans. Unfortunately, many states have adopted into these separate SCHIP plans private-insurance style limits on mental health services that would not be permissible in Medicaid, including caps on inpatient and outpatient care.

A study of SCHIP managed care plans found wide variations in the scope and limits of mental health treatment, with many states limiting outpatient services to 20 visits and inpatient days to 30 or less. These limits are not based on the medical needs of beneficiaries or best practice guidelines and result in coverage that is wholly inadequate for children with mental disorders. Another study found that children with complex mental health needs would have access to full coverage of needed services in only approximately 40 percent of states due to limited benefits in SCHIP plans.

Mental health services are key components of the range of services children need for healthy development, and children enrolled in separate SCHIP plans deserve comprehensive coverage for their mental health needs For these children to have access to appropriate range of

services, the law must be amended to ensure that all SCHIP plans provide mental health coverage that is equivalent to the coverage provided for general health care.

On February 28, 2007, over 40 national organizations representing children in the child welfare and mental health system sent a letter urging you to use this critical opportunity afforded by the SCHIP reauthorization process to prohibit disparate limits on mental health care for children in separate SCHIP plans.

Furthermore, language in the SCHIP statute even allows states to provide significantly less mental health coverage in their separate SCHIP plans than is covered in the benchmark plan they select. The law allows states that opt to create a separate plan to reduce the actuarial value of the mental health benefit by 25 percent—that is, the mental health benefit in SCHIP need only be actuarially equivalent to 75% of the benefit in the benchmark plan itself. This statutory provision authorizes states to establish SCHIP benefit packages that are totally inadequate for treating the great majority of childhood mental disorders.

This provision allowing the reduction of mental health benefits to 75 percent of the mental health benefits in the benchmark plans must be eliminated, and we commend Chairman Dingell for including a provision to do just that in his bill entitled the Children's Health First Act.

CONCLUSION

I conclusion, it is clear that many parents face tremendous barriers to accessing adequate mental health services for their children. Both the President's Commission on Mental Health and the Surgeon General have declared children's mental health coverage to be in crisis. It is

unthinkable that a child with asthma would enter the child welfare system solely to access treatment. But, for children with mental health needs, this is precisely what does happen across the country.

I urge you to take advantage of all legislative opportunities to improve access to mental health services and supports for children. Proposals before the Committee to remedy the failings of the private and public sector serving children with mental health needs must be seized to offer these children a fair chance at overcoming the extra challenges they face.

I thank you for holding this vital hearing and would be happy to answer any questions you might have.

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